PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10434

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103 Cedar St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alexander Ardis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Sarah E. Ardis

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): May 30 - 1861

8. AGE: Years: 84 | Months: 4 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Pocomoke Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: James Ardis
13. Birthplace: Accomac Co. Va.

MOTHER
14. Maiden name: Mary Walker
15. Birthplace: Accomac Co. Va.

16. Informant: Mr. George T. Ardis
Address: 305 Chester St Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 8-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Wilson & Co. Walter R. Wilson
Address: Salisbury Maryland.

19. 10/8/1945 (Date rec'd by registrar) Harriet L. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4 1945 at 3.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1945, to Oct 4 1945
and that I last saw h. alive on 19

Immediate cause of death	DURATION
Gastrointestinal obstruction	
Torpedo ventral hernia	
Due to	
Due to	
Other conditions: Cardio vascular renal disease	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo T Ardis MD
M. D. or other
Address: Salisbury Md Date signed 10-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

10435

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County: Wicomico

City or town: Mardela Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Mardela

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Ida Baker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

8.(b) Name of husband or wife: Charles E. Baker

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1888

8. AGE: Years: 65 | Months: — | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Mardela, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Thomas Pollitt

13. Birthplace: Quantico, Md.

MOTHER — 14. Maiden name: Amelia Byrd

15. Birthplace: Quantico Md.

16. Informant: Charles Baker

Address: Mardela Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/45 (month) (day) (year)

Cemetery or crematory: Mardela Cem.

Location: Mardela, Md.

18. Funeral director: David K. Merrick

Address: Hebron, Md.

19. 10/11/45 19.... W. H. Layton Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 1945, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6th 1945, to Oct. 7th 1945 and that I last saw h.. alive on October 7th 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William Emrick M. D. or other

Address: Hebron, Md. Date signed Oct. 11th 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

10436

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Annie Matilda Bounds

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: W. James Bounds

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1865.

8. AGE:

Years	Months	Days	If less than one day
80	0	15	..... hrs. ..... min.

9. Birthplace: Allen, Wicomico, Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business: ✓

FATHER

12. Name: William Malone

13. Birthplace: Wicomico Co. Md.

MOTHER

14. Maiden name: Sallie Pusey

15. Birthplace: Wicomico Co. Md.

16. Informant: Beatrice B. Bounds

Address: Fruitland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/45 (month) (day) (year)

Cemetery or crematory: Allen M. E. Church

Location: Allen, Md.

18. Funeral director: De Hill & Johnson Co.

Address: Salisbury, Md.

19. 10/3, 1945 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 1, 1945, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945, to Oct. 1, 1945

and that I last saw h[illegible] alive on ..... 19.....

Immediate cause of death	DURATION
Acute cardiac failure	
Due to	
Due to	
Other conditions Prostate	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Leslie G. Tull, M. D. or other

Address: Salisbury Md Date signed 10-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10437

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (Suburban)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days - 17 hours - 40 mins

Hospital, Institution, or street address where death occurred:

R. H. Hoyt

How long in hospital or institution? 7 days - 17 hrs - 40 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Mitchell St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME (William Kirwan Brewington) Brewington, Wm.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gertrude Brewington

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 16 - 1880

8. AGE: Years 64 | Months 9 | Days 23 | If less than one day ..... hrs. ..... min

9. Birthplace Salisbury Maryland (Town, county, and state)

10. Usual occupation Minister & Salesman

11. Industry or business

FATHER 12. Name R. Frank Brewington

13. Birthplace Salisbury Md.

MOTHER 14. Maiden name Mary White

15. Birthplace Salisbury Md

16. Informant Mrs. Gertrude Brewington

Address 310 Mitchell St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 11-45 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Maryland

18. Funeral director Mrs. Mary E. & Walter K. Wells

Address Salisbury Maryland

19. 10/11/45 Harriet E. Johnson Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 9 - 1945 at 9:25 A M

I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-25- 1945 to 10-9 1945

and that I last saw h... alive on 10-9-45 1945

Immediate cause of death Diabetes — DURATION

Due to

Due to

Other conditions Gangrene foot

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis A. Insley M. D. or other

Address Salisbury, Md. 10 - 9 - 45 Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

16438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred:

105 Cherry St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Cherry

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Augusta Caroline Byrd

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Johannas Byrd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12, 1871

8. AGE: Years 74 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Delmar, Delaware (Town, county, and state)

10. Usual occupation At home

11. Industry or business —

FATHER 12. Name Duel Hastings

13. Birthplace Delmar, Del.

MOTHER 14. Maiden name Sarah Ann Elliott

15. Birthplace Delmar, Delaware

16. Informant Mrs. Jas. Holloway

Address Delmar, Del.

17. Burial (Burial, ~~cremation,~~ or ~~removal. Which?~~) Date thereof Oct. 26 1945 (month) (day) (year)

Cemetery or ~~crematory~~ Smith Mills

Location Delmar Del. R.F.D.

18. Funeral director W. S. Marvel Co.

Address Delmar, Delaware

19. 10/26/45 (Date rec'd by registrar) 19.d/6. Maggie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940 to Oct 22 1945

and that I last saw h. alive on Oct. 21 1945

	DURATION
Immediate cause of death Ventricular Heart Disease	10 yrs
Due to	
Due to	
Other conditions Hypertension, Cerebral Apoplexy	Unknown, Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hunt R Mann M. D. or other

Address Salisbury Md Date signed 10/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46k)

10439

CERTIFICATE OF DEATH

Reg. Diat. No. 233

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred 511 S. Park Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico C.
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 S. Park Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Anna Cooper

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Roy J. Cooper
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): May 9 1896

8. AGE: Years 49 | Months 5 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Wango Maryland (Town, county, and state)
10. Usual occupation: Home Duty
11. Industry or business: At Home

FATHER
12. Name: John Kelley
13. Birthplace: Wicomico C. Md.

MOTHER
14. Maiden name: Lennia Layfield
15. Birthplace: Wicomico C. Md.

16. Informant: Mr. Roy J. Cooper
Address: 511 S. Park Drive, Salisbury Md.

17. Burial (Burial, cremation, or removal—which?) Date thereof Oct. 17-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury, Maryland

18. Funeral director: Holloway & C. Willis R. Holloway
Address: Salisbury Maryland.

19. 10/17/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1945 (2 a.m.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..19.., to Oct 15 19..
and that I last saw her alive on Oct 19..

	DURATION
Immediate cause of death: Carcinoma of Abdomen	
Primary Carcinoma of omentum.	
Due to: Duration: 8 months. Cancer	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ludwig A. Insley M. D. or other
Address Salisbury, Md. Date signed 10-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-0)

CERTIFICATE OF DEATH

10440

Reg. Dist. No. 333

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution or street Address where death occurred: R.D. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Peter Cramer

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lola V. Cramer
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Sept. 12. 1879
8. AGE: Years: 66 Months: 1 Days: 11 If less than one day: hrs. min.
9. Birthplace: Phila. Pa. (Town, county, and state)
10. Usual occupation: mechanic.
11. Industry or business: at J.D. Dulany Co.
FATHER 12. Name: Peter Cramer
13. Birthplace: Phila. Pa.
MOTHER 14. Maiden name: Wilhelmina Helms
15. Birthplace: Phila. Pa.
16. Informant: Mrs. Lola V. Cramer
Address: RD. #1. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25-1945 (month) (day) (year)
Cemetery or crematory: Head Point Cem.
Location: Head Point Md
18. Funeral director: Dillenay & C. Walter R. Dillenay
Address: Salisbury Md.
19. 10/26/45 (Date rec'd by registrar) Lamar E.L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1945 at 1.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-14 19 45 to Oct 23 19 45 and that I last saw h. alive on Oct 19 19 45

Immediate cause of death	DURATION
Carcinoma of Rectum	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Rectum
Inoperable Date of op. 5-18-45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. ~~VIOLENCE~~: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J.A. Rademacher M.D. M. D. or other
Address Salisbury Md. Date signed 10/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Evidence for the residence of the deceased is shown on Film G 99 11/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

CERTIFICATE OF DEATH

10441

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital, Salisbury

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Maud M Crippin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	B	Married

6.(b) Name of husband or wife: Ambrose Crippin

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 27, 1886

8. AGE: Years	Months	Days	If less than one day
59	7	2	hrs. min.

9. Birthplace: Snowhill Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: George Selby

FATHER — 13. Birthplace: Snowhill Maryland

MOTHER — 14. Maiden name: Eliza Blake

MOTHER — 15. Birthplace: Snowhill Maryland

16. Informant: Ambros Crippin

Address: Chincoteague Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 1 1945 (month) (day) (year)

Cemetery or crematory: Chincoteague Va

Location: Chincoteague Va

18. Funeral director: Walter M Clark

Address: Chincoteague Va

19. 11/1 1945 (Date rec'd by registrar) Harriet E Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 29th 1945, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/10 1945, to 10/29 1945

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asthenia	several months
Due to: Carcinoma of Uterus	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Uterus and bladder — Date of op. 10/17/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas F Fisher MD M. D. or other

Address: Salisbury Md Date signed: 10/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

10442

★ Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula Gen. Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Infant of Agnes Dashiell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.A	Infant

6.(b) Name of husband or wife none

8.(c) If alive, give age (no) years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1945

8. AGE:

Years	Months	Days	If less than one day
			hrs. 15 min.

9. Birthplace Salisbury Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER
12. Name Elmer Dashiell
13. Birthplace Fruitland, Maryland

MOTHER
14. Maiden name Agnes Donahue
15. Birthplace Eden, Maryland

16. Informant Mrs. Helen C. Herron
Address Eden, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Oct (day) 9 (year) 1945

Cemetery or crematory Public Cemetery

Location Salisbury, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St.

19. (Date received by registrar) 10/9/45 Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/8 19 45, to 10/8 19 45 and that I last saw h. alive on 10/8 19 45

Immediate cause of death	DURATION
Prematurity	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Rivers Hauser, M.D.
M. D. or other

Address Salisbury, Md Date signed 10/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10443

Reg. Dist. No. 331

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lean Ann Dixon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widow

6.(b) Name of husband or wife: John Dixon

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 26, 1892

8. AGE: Years: 53 Months: 1 Days: 29 If less than one day: hrs. min.

9. Birthplace: Quantico, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Worker Canning Factory

11. Industry or business:

FATHER — 12. Name: Samuel Townsend

13. Birthplace: Quantico Md.

MOTHER — 14. Maiden name: Charlotte Townsend

15. Birthplace: Quantico Md.

16. Informant: Mrs Townsend

Address: Quantico

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/28/45 (month) (day) (year)

Cemetery or crematory: Quantico Cem.

Location: Quantico Md.

18. Funeral director: Dan'l C. Ipsenck

Address: Hebron Md.

19. 10/25 19 45 (Date rec'd by registrar) Mrs J M Walls Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/24/45 19 at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 to Oct 24 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to Chronic Myocarditis	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clara T. Fisher M.D. M. D. or other

Address: Salisbury Md. Date signed: 10/26/45

Deputy Medical Examiner

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 323

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wor.

City or town Bishopsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME John Walker Mr. Frank

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4th 1901

8. AGE: Years 44 | Months 7 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Bishopsville Md. (Town, county, and state)

10. Usual occupation Tabacco

11. Industry or business Day Work

FATHER 12. Name Walker Mr. Eduard

13. Birthplace Bishopsville Md.

MOTHER 14. Maiden name Nicholson Miss Lunnie E.

15. Birthplace Snow Hill, Md.

16. Informant Mrs. Annie Walker

Address Bishop, Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof Oct. 23, 1945 (month) (day) (year)

Cemetery or crematory Bishopsville

Location Worcester Co. Maryland

18. Funeral director Mr. Pasha Watson

Address Selbyville Del.

19. 11/16/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 20 1945, at 6 Ex p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Fractured skull	2 hours
Lacerated Brain	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10/19/45

Where did injury occur? near Delmar (City or town) Wicomico (County) Del (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Automobile accident Injured at work? No

23. SIGNATURE Postmaster MD Postmaster Med Examiner M. D. or other

Address Salisbury, Md. Date signed 10/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

10444

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: 106½ Liberty street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 106½ Liberty St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred May Hinkle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ernest B. Hinkle
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 16-1897

8. AGE: Years: 48 | Months: 4 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Deal Island Md.
(Town, county, and state)

10. Usual occupation: Fore Lady

11. Industry or business: Shirt Factory

FATHER
12. Name: John Henry Layfield
13. Birthplace: Deal Island Md.

MOTHER
14. Maiden name: Nettie C. Webster
15. Birthplace: Deal Island Md.

16. Informant: Mr. Ernest B. Hinkle
Address: 106½ Liberty St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 16-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 10/16/45 (Date rec'd by registrar) 13. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4 1945 at 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3 1945, to Oct. 4 1945
and that I last saw her alive on Oct. 3 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed: 10/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

10445

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hrs

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 9 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Somerset Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Holland, Mrs Sadie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: Edward J. Holland

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): September 5, 1891

8. AGE: Years: 54 Months: 1 Days: 1 If less than one day: ...hrs. ...min.

9. Birthplace: Crisfield-Somerset-Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER — 12. Name: Charlie Sterling

FATHER — 13. Birthplace: Crisfield, Maryland

MOTHER — 14. Maiden name: Mary Upper

MOTHER — 15. Birthplace: Crisfield, Maryland

18. Informant: E. J. Holland

Address: Crisfield, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Oct. 8, 1945

Cemetery or crematory: Crisfield Cemetery

Location: Crisfield, Maryland

18. Funeral director: H. Harvey Bradshaw

Address: Crisfield, Maryland

19. (Date rec'd by registrar) October 9 1945 Earle E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 6 1945 at 5.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... to ... 19...

and that I last saw her alive on ... 19...

Immediate cause of death: Fractured skull

Due to: Brain injury

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10-5-45

Where did injury occur? Laurel (City or town) Sussex (County) Del (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Struck by car Injured at work? No

23. SIGNATURE: J. A. Cademartori M.D. Deputy Med. Examiner M. D. or other

Address: Salisbury, Md. Date signed: 10/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the addition of age and year is shown on FILM No. G99 NOV 1 194

10446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 Mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Som.
City or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lena Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	

6.(b) Name of husband or wife Walter Jackson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
47			hrs. min.

9. Birthplace Som. Co., Md. (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Arnold Jones
13. Birthplace Som. Co., Md.

MOTHER
14. Maiden name
15. Birthplace

16. Informant Ella Carr
Address Princess Anne, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/ 1945 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director William H. Jones Jr
Address Princess Anne, Md.
19. 10/3 1945 Received by Ella Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3rd 1945, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5th 1945, to Oct 3 1945
and that I last saw h.er alive on Oct. 3rd 1945

Immediate cause of death	DURATION
Cardiac Disease due to Overweight	
Due to Malignancy of cervix	
Other conditions Pr. of Cervix & Edema	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jack K. Williams MD
M. D. or other
Address Salisbury Md. Date signed 10-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10447

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? From 2 55 am 4 55 am (2 hrs)

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jones, Baby Girl

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hrs. ..... min.

9. Birthplace: Enroute to Hospital in Taxi cab. (Town, county, and state)

10. Usual occupation: Between - Fruitland & Salisbury Md.

11. Industry or business

FATHER

12. Name: Edward Jones

13. Birthplace: Fruitland Md.

MOTHER

14. Maiden name: Doris Hooper

15. Birthplace: Boothwyn, Pa.

16. Informant: William A. Hooper

Address: 318 Anne St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/1945 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & G. Walter R. Holloway

Address: Salisbury Md.

19. 10/19/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1945, at 4 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/17 1945, to 10/17 1945 and that I last saw h[illegible] alive on 10/17 1945

	DURATION
Immediate cause of death: Premature Labor	
Due to: Premature Labor	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. Rivers Hanson M.D.

M. D. or other

Address: Salisbury, Md. Date signed 10/19/45

Wicomico

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Mann

10448

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.B. Wright.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1
(If rural, give LOCATION)
2.(c) If veteran, name war

3.(a) FULL NAME: Martha Ellen Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: Alfred J. Jones
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): Dec. 7 - 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	10	15		

9. Birthplace: R.D. Fruitland Md. (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: Benjamin Peter Lynnstone
13. Birthplace: R.D. Fruitland Md.

MOTHER
14. Maiden name: Martha Carey
15. Birthplace: R.D. Fruitland Md.

16. Informant: Mr. Alfred J. Jones
Address: R.D.#1 Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. 10/26/45 (Date rec'd by registrar) 1945 Cassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22nd 45 at 11:58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, to Oct 22 1945 and that I last saw her alive on Oct 22 1945

	DURATION
Immediate cause of death: Depression	1 week
Due to: Multiple Kidney Stones with Calculous Pyelitis both Kidneys	8 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hunter R. Mann M. D. or other
Address: Salisbury Md. Date signed: 10/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days.
Hospital, institution, or street address where death occurred: Peninsula General Hospl. Salisbury
How long in hospital or institution? 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ruth Jones

3.(b) Social Security Number 218-16-9041

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

B.(b) Name of husband or wife: Jones Jones
6.(c) If alive, give age: 22 years
7. Birth date of deceased (mo., day, yr.): April 22-1926

8. AGE:

Years	Months	Days	If less than one day
19	6	3	...hrs. ...min.

9. Birthplace: Pocomoke Worcester Md.
(Town, county, and state)
10. Usual occupation: Clerk Navy Base
11. Industry or business
FATHER 12. Name: Elijah C. Wright
13. Birthplace: Virginia
MOTHER 14. Maiden name: Rose Mae Mariner
15. Birthplace: Virginia
16. Informant: Elijah C Wright
Address: Stockton Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28 1945 (month) (day) (year)
Cemetery or crematory: Hollis Hill Bapt
Location: Pocomoke Md.
18. Funeral director: Nygaard Stanton
Address: Pocomoke Md.
19. (Date rec'd by registrar) 10/28/45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1945 at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16 1945 to Oct. 25 1945 and that I last saw h[er] alive on Oct. 25 1945

Immediate cause of death	DURATION
Pulmonary Gangrene	
Due to: Etiology unknown	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Rivers Hanson, M.D.
M. D. or other
Address: Salisbury Md. Date signed 10/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

10450

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: John B. Parsons Home
How long in hospital or institution? 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: John B. Parsons
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Harriet L. Lewis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry A. Lewis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1860.

8. AGE: Years: 85 Months: 8 Days: 17 If less than one day: hrs. min.

9. Birthplace: Mason Neck, Penna. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Francis T. Anderson
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Sophia Payne
15. Birthplace: Maryland

16. Informant: John B. Parsons Home, Supt.
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/45 (month) (day) (year)
Cemetery or crematory: Parsonage
Location: Linwood, Penna.
18. Funeral director: De Hill Johnson Co.
Address: Salisbury, Md.

19. 10/3 (Date rec'd by registrar) 1945 Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4, 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25th 1945, to October 2nd 1945 and that I last saw h[illegible] alive on October 1, 1945.

Immediate cause of death	DURATION
Embolus.	
Due to Thrombus in Muscle of Heart.	
Due to Arterio sclerosis & Myocarditis.	
Other conditions Marked enlargement of Heart.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Carrie L. Heare M.D. M. D. or other
Address: 203 W. Church St. Salisbury Md. Date signed: 10/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10?)

16451

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Jessie Mallory

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6 - 1872

8. AGE: Years	Months	Days	If less than one day
73	3	1	hrs. min.

9. Birthplace: Gremville Alabama (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Walter C. Dennis
Address: Newark, Md Rural #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 9/45 (month) (day) (year)
Cemetery or crematory: Cedar Chapel
Location: Newark
18. Funeral director: Deane & Dennis
Address: Snow Hill, Md
19. 10/9 1945 Harriet L. Johnson Registrar
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1945, at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1945, to Oct 7 1945
and that I last saw h[illegible] alive on Oct 7 1945

Immediate cause of death	DURATION
Pneumonia	7 days
Lobar	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. A. Calendar M. D. or other
Address: Salisbury Md Date signed: 10/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 10452 — 23-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: Third St (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mary Marshall

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	w.	married

6.(b) Name of husband or wife: George Marshall

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1894

8. AGE: Years: 51 about; Months; Days; If less than one day: hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Same as above

FATHER — 12. Name: Thomas Jones

FATHER — 13. Birthplace: Salisbury Md

MOTHER — 14. Maiden name: Schaffett

MOTHER — 15. Birthplace: Salisbury Md

16. Informant: Mrs Addie Bremington

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11-1945 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 10/11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9th 1945 at 4.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/8 1945 to 10/9 1945 and that I last saw her alive on 10/8 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs.
Due to: Hypertension	about 2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas T. Fisher, M.D. M. D. or other

Address: Johnson Salisbury Md Date signed: 10/10/45

10453

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8/10/45
Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
How long in hospital or institution? 8/10/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin, Rt.#2, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Marshall, William Wesley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mildred Quillen Marshall
6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1896

8. AGE: Years	Months	Days	If less than one day
49	0	2	hrs. min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business

FATHER
12. Name: William Franklin Marshall
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lila Nottingham
15. Birthplace: Virginia

16. Informant: Mr. Lloyd Marshall
Address: Willards Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 10/17/45 (month) (day) (year)
Cemetery or crematory: Taylorsville
Location: Berlin Md R.F.D.
18. Funeral director: Annie A. Burbage
Address: Berlin Md

19. (Date rec'd by registrar) 10/17/45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1945 at 2 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 1945 to Oct. 14 1945 and that I last saw him alive on Oct. 14 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis,	6 mts.
Infiltration Apex R-5, both sides.	
Due to Cav. T.B.	
No pneumonia.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul [illegible] (Coroner) M. D. or other
Address: Salisbury, Maryland Date signed: 10/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10454

Reg. Dist. No. 339

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Years

Hospital, Institution, or street address where death occurred:

119 South Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md, County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 224 Camden Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clara G. Mayne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William G. Mayne

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1902

8. AGE: Years	Months	Days	If less than one day
43	0	27	hrs. min.

9. Birthplace: Chance, Somerset, Co. Md. (Town, county, and state)

10. Usual occupation: Restaurant Owner

11. Industry or business

FATHER — 12. Name: Warren C. Gladden

13. Birthplace: Chance Md

MOTHER — 14. Maiden name: Clara Reenes

15. Birthplace

16. Informant: Mrs William G. Mayne Jr.

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/ 21/ 45 (month) (day) (year)

Cemetery or crematory: Asbury M. E.Church Cemetery

Location: Mt.Vernon, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 10/21/ 19 46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 19, 1945 19 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to [illegible] 19

and that I last saw [illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J.A. Rademaker Deputy Med Examr. M. D. or other

Address: Salisbury Md Date signed: 10/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

CERTIFICATE OF DEATH

10455

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel F. Miles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

B.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 - 1865

8. AGE: Years	Months	Days	If less than one day
80	4	4	hrs. min.

9. Birthplace Somerset Co. (Town, county, and state)
10. Usual occupation Civil Engr. & Farmer
11. Industry or business

FATHER
12. Name Wm F. W. Miles
13. Birthplace Somerset Co.

MOTHER
14. Maiden name Sarah E. Costen
15. Birthplace Somerset Co.

16. Informant W. Ballard Miles
Address Oak St. Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26, 1941 (month) (day) (year)
Cemetery or crematory St Andrews Cem.
Location Princess Anne Md

18. Funeral director Dale Dashiell
Address Princess Anne Md.

19. 10/25/41 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1941 at 9.40 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 21 1941 to Oct 24 1941 and that I last saw h[illegible] alive on Oct 24 1941

Immediate cause of death	DURATION
Chronic endocarditis	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Bowman M. D. M. D. or other
Address Salisbury Md. Date signed Oct 27 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10456

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Maude Moss.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: James H. Moss

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): March 2, 1882

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: New York State (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: James Moss

Address: Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 25 1945 (month) (day) (year)

Cemetery or crematory: Episcopal Cemetery

Location: Princess Anne, Md.

18. Funeral director: Wade Wardrell

Address: Princess Anne, Md.

19. 10/25/1945 (Date rec'd by registrar) Harriet E. Dennis Registrar

Seal

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23- 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/8 1945 to 10/23 1945 and that I last saw h-er alive on 10/23 1945

Immediate cause of death	DURATION
Lobar Pneumonia (terminal).	2 days
Due to: Cerebrovascular syphilis	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. T. Fisher M.D. M. D. or other

Address: Salisbury, Md. Date signed: 10/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10457

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22nd)

CERTIFICATE OF DEATH

Reg. Dist. No. 328

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury R.D. #3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution or street address where death occurred: Delmar Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. 3 Delmar Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George Washington Murphy

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Margaret P. Murphy

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Sept. 12-1869

8. AGE: Years: 76 | Months: 1 | Days: 16 | If less than one day: hrs. ____ min. ____

9. Birthplace: Brookview Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

FATHER — 12. Name: Grayson Murphy

13. Birthplace: Dorchester Co. Md.

MOTHER — 14. Maiden name: Mary Creeman

15. Birthplace: Dorchester Co. Md.

16. Informant: Mrs. Margaret P. Murphy

Address: R.D. 3 Delmar Road Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 30-1945 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland

19. 10/26/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 28 1945 at 1130 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15 1945, to 10/28 1945

and that I last saw him alive on 10/26 1945

Immediate cause of death: Valvular Heart Disease — DURATION: 2 yrs.

Due to:

Due to:

Other conditions: Gall Stones — Duration:

Hypertrophy Prostate — 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis R Moore M. D. or other

Address: Salisbury Md. Date signed: 10/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-D)

CERTIFICATE OF DEATH

10458

Reg. Diat. No. 321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wisconsin
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wisconsin
City or town: Quantico
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Williams Edward Parratt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Theresa Parratt
6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	19	hrs. min.

9. Birthplace: Talbot Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Not Known
13. Birthplace
MOTHER 14. Maiden name: Not Known
15. Birthplace
16. Informant: Mrs Jay French
Address: Quantico, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/7/45 (month) (day) (year)
Cemetery or crematory: Quantico Churchyard
Location: Quantico Md
18. Funeral director: Geo Hill & Johnson
Address: Salisbury, Md
19. Oct 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1st 1945 to Oct. 4th 1945
and that I last saw h— alive on October 4th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Helen - Md Date signed: Oct. 7th 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-C

CERTIFICATE OF DEATH

10453

★Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, Institution, or street address where death occurred: 413 Wales St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 413 Wales Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward James Pointer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude Pointer
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): March 20-1874

8. AGE:

Years	Months	Days	If less than one day
71	6	14	hrs. min.

9. Birthplace: Accomac Co. Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: James Pointer
13. Birthplace: New Jersey
MOTHER 14. Maiden name: Rebecca Ann Jadgen
15. Birthplace: New Jersey
16. Informant: Mrs. Gertrude Pointer
Address: 413 Wales St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-16-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 10/16/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1945, at 8 40 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Oct. 3 1945
and that I last saw him alive on Oct. 3 1945

Immediate cause of death	DURATION
Carcinoma of Prostate	
Cardiac Decompensation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed: 10/5/45

10460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: Peninsula Gen Hospital

How long in hospital or institution? one month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Wade

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Chester Quinton

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

B.(b) Name of husband or wife: Cassie Quinton

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): about 1878

8. AGE:

Years	Months	Days	If less than one day
67 about			..... hrs. ..... min.

9. Birthplace: Shraptown Wicomico Co Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Same as above

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

18. Informant: Mrs Evelyn Cattman

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1945 (month) (day) (year)

Cemetery or crematory: Hanton

Location: Salisbury md

18. Funeral director: James A. Stewart

Address: Salisbury md

19. 10/16 1945 Harriet L. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 1945, to Oct 11 1945

and that I last saw h... alive on Oct 11 1945

Immediate cause of death	DURATION
Chr. Myocarditis	last
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: /

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: /// Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Date signed 10/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Gray

10461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: P.R. Hospt.
How long in hospital or institution? 6 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. RD.#2 Anderson Road (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice May Short

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife William J. Short
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) March 7 - 1882
8. AGE: Years 63 Months 7 Days 16 If less than one day ....hrs. ....min.
9. Birthplace Salisbury Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business at Home
FATHER 12. Name Charles Davis Nicholson
13. Birthplace Salisbury Md.
MOTHER 14. Maiden name Elizabeth Louise White
15. Birthplace Salisbury Md.
16. Informant Mr William J. ~~H~~ Short
Address RD.#2 Salisbury Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 26-45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 10/26, 19 45 (Date rec'd by registrar) Lassie E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23rd 19 45, at 2:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 19 45, to Oct 23 19 45 and that I last saw her alive on Oct 23 19 45

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to Arteriosclerotic hypertensive C-V Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE Jno. D. Gray M. D. or other
Address Salisbury, Md. Date signed 10/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 11 — 10463 336

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:
County: Wicomico Md.
City or town: Delmar Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar Maryland (If outside city or town limits, write RURAL and give nearest town)
Street No.: State Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Viola Lingo Sirman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edwin Sirman
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 16th 1875

8. AGE: Years 70 | Months 4 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
12. FATHER — Name: Joseph H. Lingo
13. FATHER — Birthplace: Delaware
14. MOTHER — Maiden name: Lydia Neste Chase
15. MOTHER — Birthplace: Delaware
16. Informant: Edwin Sirman
Address: Delmar Delaware
17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 7 1945 (month) (day) (year)
Cemetery or crematory: Mechanics Millsboro Del.
Location: Millsboro Del. Cemetery
18. Funeral director: Townsend & Co.
Address: Salisbury Md.
19. October 5 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4 1945, at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Oct 4 1945
and that I last saw h[illegible] alive on Oct 4 1945

	DURATION
Immediate cause of death: Anemia	12 hrs
Due to: Chronic Labyrinth Disease of middle ears	6 yrs
Due to: Chronic Nephritis	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J H Lynch M. D. or other
Address: Delmar Del. Date signed: Oct 6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94E)

CERTIFICATE OF DEATH

10463

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred: John B. Parsons Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: John B. Parsons Home (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie E. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27 1877

8. AGE: Years	Months	Days	If less than one day
68	2	23	hrs. min.

9. Birthplace: Worcester Co Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER 12. Name: Stansbury Smith

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary E. Phillips

15. Birthplace: Maryland

16. Informant: John B. Parsons Home

Address: Salisbury

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/22/45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: Geo. H. Hill & Johnson

Address: Salisbury Md

19. 10/22 19 45 Harriet E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 19 45, at 12 40 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 19 45 to Oct 20 19 45

and that I last saw him alive on Oct 19 19 45

Immediate cause of death	DURATION
Angina	1 week.
Due to: Hypertension	Uncertain
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howe R Mann M. D. or other

Address: Salisbury Md Date signed 10/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

10464

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary Elizabeth Smith

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Arden H. Smith ✓
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1860.

8. AGE:

Years	Months	Days	If less than one day
85	8	17	..... hrs. ..... min.

9. Birthplace: Allen, Wicomico, Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓

FATHER
12. Name: Henry Lee Hearn
13. Birthplace: Leesburg, Va.

MOTHER
14. Maiden name: Elizabeth Ann Allen
15. Birthplace: Wicomico Co., Md.

16. Informant: Joseph T. T. Smith
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/3/45. (month) (day) (year)
Cemetery or crematory: Allen M. E. Church
Location: Allen, Wicomico Co., Md.

18. Funeral director: L. E. Hill, Wicomico Co.
Address: Salisbury, Md.

19. 10/3 (Date rec'd by registrar) 1945 Rascie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 1, 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1945, to Oct 1 1945
and that I last saw h alive on Oct 1, 1945

Immediate cause of death	DURATION
Uremia	
Due to: Chronic nephritis	
Due to: Fract Leg, due to a fall	
Other conditions: Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: August, 1945.
Where did injury occur? Allen, (City or town) Wicomico, (County) Maryland. (State)
Injured at home, farm, industry, public place (where?): At Home.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Floyd A Insley M. D. or other
Address: Salisbury Md Date signed: 10-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

CERTIFICATE OF DEATH

10465

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution or street address where death occurred: P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 Race Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Ellen Smullen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Walter Smullen
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 17-1911

8. AGE: Years	Months	Days	If less than one day
33	11	16	____ hrs. ____ min.

9. Birthplace Frankford Del. (Town, county, and state)
10. Usual occupation Worker at
11. Industry or business Wood working Plant

FATHER
12. Name Daniel E. Mitchell
13. Birthplace Salisbury Md.

MOTHER
14. Maiden name Julia Ellen Tunney
15. Birthplace Frankford Del

16. Informant Mrs. Julia E. Mitchell
Address 313 Race St Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 6-45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.

18. Funeral director Hollowell & Co. Walter R. Holloway
Address Salisbury Md.

19. 10/6 1945 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3-45 19 45 at 1300 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 3 1945
and that I last saw h.r. alive on Oct 3, 1945

Immediate cause of death	DURATION
Carcinoma Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hedley C. Finch M. D. or other
Address Salisbury Md Date signed 10-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10466

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: RD #2 Eden Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Md., County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #2 Eden Md.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: John E. Taylor
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Jan 4- 1882

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: Allen Maryland (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business: at Home

FATHER
12. Name: Robert James Steward
13. Birthplace: Allen Md.

MOTHER
14. Maiden name: Sallie Disharoon
15. Birthplace: Allen Md.

16. Informant: Mr. John E. Taylor
Address: RD. #2 Eden Md.

17. Buried (Burial, cremation, or removal. Where?) Date thereof: Oct. 8-1945 (month) (day) (year)
Cemetery or crematory: Allen Church Cem.
Location: Allen Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. 10/8/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6th 1945, at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw deceased alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

28. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. Katherine Mac Liberty Med Exam M. D. or other
Address: Salisbury Md. Date signed 10/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10467

Reg. Diat. No. 393

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 Months
Hospital, institution, or street address where death occurred:
105 Cherry St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Nelson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(o) If veteran, name war

3.(a) FULL NAME Lizzie Estella Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife Lewis Lee Taylor
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 16, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	27	____ hrs. ____ min.

9. Birthplace Shaptown, Wicomico, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William James Bradley
13. Birthplace Shaptown, Md.
MOTHER 14. Maiden name Margaret Cooper
15. Birthplace Shaptown, Md
16. Informant Mrs. William Stephens
Address Nelson Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/45 (month) (day) (year)
Cemetery or crematory Red Men's Cemetery
Location Shaptown Md.
18. Funeral director David E. Messick
Address Nelson Md.
19. 10/16 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1945, at 4:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4th 1945 to October 11th 1945 and that I last saw h... alive on October 11th 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William E. Messick M. D. or other
Address Nelson Md. Date signed October 15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

10468

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address (where death occurred): Salisbury Peninsula General Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Edith Teagle

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: John H. Teagle
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Unknown 1898

8. AGE: Years	Months	Days	If less than one day
47	—	—	..... hrs. ..... min.

9. Birthplace: Pocomoke Worcester Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: William Moore
13. Birthplace: Md.

MOTHER
14. Maiden name: Jennie Long
15. Birthplace: Md.

16. Informant: John H. Teagle
Address: R.D. Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9 1945 (month) (day) (year)
Cemetery or crematory: Waddtown Cemetery
Location: Rural Pocomoke Md.

18. Funeral director: Margaretta Newton
Address: Pocomoke Md.

19. 10/9 1945 Harriet J. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7 1945 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/26 1945, to 10/7 1945 and that I last saw h— alive on 10/7 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	Hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: 10/9/45

10463

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

Apple Road

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If onside city or town limits, write RURAL and give nearest town)

Street No. Apple Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Bertha Thomas

3.(b) Social Security Number 213-16-7473

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B.(b) Name of husband or wife Harvey Thomas

8.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) March 30, 1908

8. AGE: Years	Months	Days	If less than one day
37	6	17	...hrs. ...min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name John Hinman

13. Birthplace Virginia

MOTHER 14. Maiden name Georgia Wise

15. Birthplace Virginia

16. Informant Harvey Thomas

Address Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 22, 1945 (month) (day) (year)

Cemetery or crematory Mardela Methodist Cemetery

Location Mardela Springs, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. ...19... (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945, at 11:50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/14 1945, to October 17 1945 and that I last saw h. GR alive on OCTOBER 17 1945

Immediate cause of death	DURATION
MYOCARDIAL FAILURE	2 days
Due to CHRONIC NEPHRITIS WITH EDEMA.	18 MOS.
Due to ESSENTIAL HY PERTENSION	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Cooke M. D. or other

Address Cambridge Md Date signed 10/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10470

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: 306 Light Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Light Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Emma Truitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Hiram James Truitt
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 26 1865

8. AGE: Years	Months	Days	If less than one day
80	3	10	...hrs. ...min.

9. Birthplace: P.O. Pittsville Md.
(Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home

FATHER
12. Name: Jeremiah Jones
13. Birthplace: Pittsville Md.

MOTHER
14. Maiden name: Mary Jane West
15. Birthplace: Sussex Co. Del.

16. Informant: Mrs. Alma Beauchamp.
Address: 306 Light St. Salisbury Md

17. Burial
(Burial, cremation, or removal, which?)
Date thereof: Oct. 9 1945
(month) (day) (year)
Cemetery or crematory: Pittsville Cem.
Location: Pittsville Maryland

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.

19. 10/9/1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1945 at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Oct 6 1945
and that I last saw h.e.r. alive on Oct 6, 1945 1945

Immediate cause of death	DURATION
Acute cardiac failure	
Due to	
Due to Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Glenn A. Truitt M. D. or other
Address: Salisbury Md Date signed: 10-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 99 DEC 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

10471

★Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Grace Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widow

6.(b) Name of husband or wife: Frank Turner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 12th 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79 80	10	3		

9. Birthplace: Onancock Va (Town, county, and state)
10. Usual occupation: Home work
11. Industry or business: own Home

FATHER
12. Name: Unknown
13. Birthplace: " "

MOTHER
14. Maiden name: Rebecca Bailey
15. Birthplace: Va.

16. Informant: Wade Bailey
Address: Tyaskin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 17 1945 (month) (day) (year)
Cemetery or crematory: Tyaskin Md
Location: " Church

18. Funeral director: E. E. Messick
Address: Pittsville Md

19. Oct 16 1945 (Date rec'd by registrar) R. Woolford Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15 1945 at 11a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 1945 to Oct 15 1945
and that I last saw h. alive on Oct 11-45 1945

Immediate cause of death	DURATION
Apoplexy	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D Allen Smith M. D. or other
Address: Westover Md. Date signed 10-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10472

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
E. S. Tuberculosis Sanatorium

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 Smith Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Preston W. Underhill

3.(b) Social Security Number 223-18-6132

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	married

6.(b) Name of husband or wife Dorothy Eleanor Underhill

7. Birth date of deceased (mo., day, yr.) Aug 13, 1911 — 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
34	2	18	..... hrs. ..... min.

9. Birthplace Northampton Co Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Alonzo H. Underhill

13. Birthplace Northampton Co Va.

MOTHER 14. Maiden name Bertie Killman

15. Birthplace Accomack Co.

16. Informant Alonzo H. Underhill Jr.

Address Kellel, Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1945 (month) (day) (year)

Cemetery or crematory Bellehaven Cemetary

Location Bellehaven, Va.

18. Funeral director Burbage & Johnson

Address Onancock Va.

19. 10/31/1945 (Date rec'd by registrar) Harris E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 19 45 at 3:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/45 19.. to 10/31/45 19.. and that I last saw him alive on October 30 19 45

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	2 yr.
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul Ellis M. D. or other

Address Snow Hill, Maryland Date signed 10/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

10473

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3.(a) FULL NAME: Unknown

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A A	unknown

6.(b) Name of husband or wife: unknown

unknown 6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Unknown			....hrs. ....min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER — 12. Name: Unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: unknown

16. Informant: ....

Address: ....

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 12-1945 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury Md

18. Funeral director: Jones & Stewart

Address: Salisbury Md

19. 10/12/1945 (Date rec'd by registrar) Harriet L. Johnson (Registrar)

Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Unknown 19.... at .... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19.... to Sept 19....

and that I last saw h.... alive on Sept 19....

	DURATION
Immediate cause of death: Drowning	Sudden death
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: ....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of ....

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): River

Means of injury: Fell in river Injured at work? No

23. SIGNATURE: Lee Redeman Deputy Med Examiner

M. D. or other

Address: Salisbury Md Date signed 10/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

10474

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, Institution, or street address where death occurred: P.G. Hospital Salisbury Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Clarence L. Vincent

3.(b) Social Security Number: The Democratic Messenger Snow Hill, Md

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia L. Vincent

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Sept. 5 - 1861

8. AGE:

Years	Months	Days	If less than one day
84	1	6	..... hrs. ..... min.

9. Birthplace: Salisbury Wicomico Md (Town, county, and state)

10. Usual occupation: Public School Teacher

11. Industry or business: The Democratic Messenger Snow Hill Md

FATHER 12. Name: Thomas Vincent

13. Birthplace: Maryland

MOTHER 14. Maiden name: Carrie Goodwin

15. Birthplace: Maryland

16. Informant: Mrs Virginia L. Vincent

Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14/45 (month) (day) (year)

Cemetery or crematory: Presbyterian

Location: Snow Hill, Md

18. Funeral director: Keane & Timmons

Address: Snow Hill Md

19. 10/14 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/7 1945 to 10/11 1945

and that I last saw h... alive on 10/11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

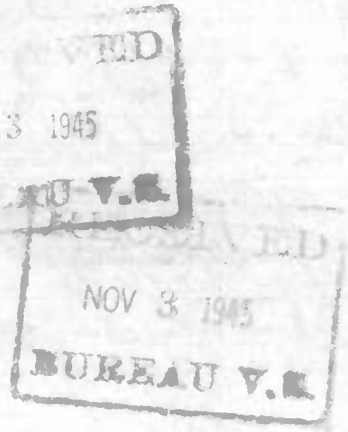
23. SIGNATURE: Edna E. Fisher M.D. M. D. or other

Address: Salisbury Md Date signed: 10/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

10475

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County: Suffolk

City or town: Rocky Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Radio Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Joseph Weber

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Anna Weber

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): June 11 - 1874

8. AGE: Years: 71 Months: Days: If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business:

FATHER — 12. Name: Geo. Weber

13. Birthplace: Germany

MOTHER — 14. Maiden name: Catharine Dangle

15. Birthplace: Germany

18. Informant: Joseph Weber

Address: Delmar, Del. R. D. #1

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Oct. 26 1945 (month) (day) (year)

Cemetery or crematory: St. James

Location: Port Jefferson, N. Y.

18. Funeral director: W. S. Marvel Co.

Address: Delmar, Delaware

19. (Date rec'd by registrar) 10/29/45 — Harriet E. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1945, to Oct 22 1945, and that I last saw h[illegible] alive on Oct 22 1945.

Immediate cause of death	DURATION
Cer. Hemorrhage	Instt
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ✓ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Date signed: 10/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gray

10495

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 233

1. PLACE OF DEATH: Wicomico

County .....

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, Institution, or street address where death occurred: 121. E. Phila. Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121. E. Phila. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME William Clayton White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie E. White

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb. 27- 1876

8. AGE: Years 69 | Months 7 | Days 28 | If less than one day .....hrs. .....min.

9. Birthplace Po. Laurel Delaware (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Lumber Mill

FATHER — 12. Name John White

FATHER — 13. Birthplace Po. Laurel Delaware

MOTHER — 14. Maiden name Hitch

MOTHER — 15. Birthplace — Delaware

16. Informant Mrs. Annie E. White

Address 121. E. Phila, Ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 27-1945 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Maryland

18. Funeral director Dillon & Co. Walter K. Dillon

Address Salisbury Maryland.

19. 10/27/1945 (Date rec'd by registrar) Lassie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25th 1945 at 2.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24 1945, to Oct. 25 1945

and that I last saw h... alive on Oct 24 1945

Immediate cause of death	DURATION
Acute Depression	
Due to Dehydration	
Due to Cerebral Arteriosclerosis	
Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dan'l D. Gray M. D. or other

Address Salisbury, Md Date signed 10/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

10477

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 39 mos. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hebron

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME White, Miss Carrie Gilchrist

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 31 1875

8. AGE: Years 70 | Months 2 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Tyaskin, Wicomico Co. Md. (Town, county, and state)

10. Usual occupation Shirt Factory operator

11. Industry or business Gordy Party Factory

FATHER 12. Name Ebenezer White

13. Birthplace Tyaskin, Md.

MOTHER 14. Maiden name Mary Mills

15. Birthplace Tyaskin Md.

16. Informant Miss Elsie White

Address Willow Grove, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)

Cemetery or crematory Hebron Cem.

Location Hebron Md.

18. Funeral director David E. Megee

Address Hebron, Md.

19. 10/24 1945 Harriet E. Johnson Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1945, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 1945, to Oct 22 1945

and that I last saw h... alive on Oct 22 1945

	DURATION
Immediate cause of death: Peritonitis	2 days
Due to: Ruptured Gangrenous appendix	3 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: General peritonitis & Ruptured gangrenous appendix Date of op. 10-21-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Salisbury Md. Date signed 10/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

10476

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2

Hospital, institution, or street address where death occurred: P. H. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Eden (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ornie Willey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Madeline Willey

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Aug 4, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	12	..... hrs. ..... min.

9. Birthplace: Eden, Somerset Co, Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Willey

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Ella Nash

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Ornie Willey

Address: Eden, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/45 (month) (day) (year)

Cemetery or crematory: Allen Cemetery

Location: Allen, Md

18. Funeral director: The Hill & Johnson Co

Address: Salisbury, Md

19. 10/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1945 at 11 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 16 1945 and that I last saw him alive on Oct 16 1945

Immediate cause of death	DURATION
(a) Pneumonia	3 days
Due to: Chronic nephritis	
Duration: Not stated.	
Due to: C.W.S.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. R. Wammer M.D. (M. D. or other)

Address: Salisbury, Md Date signed: Oct 18 1945

Evidence for residence of deceased is shown on Film No. G99 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10478

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred: Penn General Hospital
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Hurlbert Young

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Mary Gamble
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9. 1864

8. AGE:

Years	Months	Days	If less than one day
80	10	3	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Retired insurance
11. Industry or business
FATHER 12. Name: Mason Young
13. Birthplace: N. Y.
MOTHER 14. Maiden name: Louise Hurlbert
15. Birthplace: N. Y.
16. Informant: Mason Young
Address: Miami. Fla.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14 1945 (month) (day) (year)
Cemetery or crematory: St. Andrews
Location: Princess Anne
18. Funeral director: P. M. Smith
Address: Princess Anne.
19. 10/14 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-12 1945, at 4:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to 10-12 1945
and that I last saw h... alive on 10-11 1945

Immediate cause of death	DURATION
Carcinoma of stomach	3 mos.
Due to	
Due to	
Other conditions: General peritonitis from perforation of carcinoma	5 days

(Include pregnancy within 3 months of death)
Major findings of operations: General peritonitis
Date of op.: 10-8-45
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker MD M. D. or other
Address: Salisbury Md. Date signed: 11/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15